

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0021394

Facility Name: BIG MEADOWS

Address: 1000 LONGMOOR SAVANNA 61074
Number City Zip Code

County: CARROLL

Telephone Number: 815-273-2238 Fax # 815-273-7294

HFS ID Number:

Date of Initial License for Current Owners: 10/21/1976

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

xx PROPRIETARY

Individual

Partnership

xx Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Julie Johnson

(Title) Administrator

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

In the event there are further questions about this report, please contact:
Name: Robin Landis Telephone Number: 815-778-3683
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Facility Name & ID Number

BIG MEADOWS

#

0021394

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1		Skilled (SNF)		1
2		Skilled Pediatric (SNF/PED)		2
3	83	Intermediate (ICF)	83	30,295
4		Intermediate/DD		4
5		Sheltered Care (SC)		5
6		ICF/DD 16 or Less		6
7	83	TOTALS	83	30,295

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9		
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other		Total
				Medicaid Primary	Medicare Primary					
8	SNF								8	
9	SNF/PED								9	
10	ICF	4,934	12,229	384		4,340		21,887	10	
11	ICF/DD								11	
12	SC								12	
13	DD 16 OR LESS								13	
14	TOTALS	4,934	12,229	384		4,340		21,887	14	

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

72.25%

D. How many bed reserve days during this year were paid by the Department?

0

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

1/11/1976

J. Was the facility purchased or leased after January 1, 1978?

YES

Date

NO

X

K. Was the facility certified for Medicare during the reporting year?

YES

NO

X

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2025

Fiscal Year:

12/31/2025

* All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	312,486	48,952	10,950	372,388		372,388		372,388			1
2	Food Purchase		202,723		202,723		202,723	(6,772)	195,951			2
3	Housekeeping	128,312	27,910		156,222		156,222		156,222			3
4	Laundry	100,927	8,786		109,713		109,713		109,713			4
5	Heat and Other Utilities			191,092	191,092		191,092	(3,800)	187,292			5
6	Maintenance	135,701	29,877	34,700	200,278		200,278		200,278			6
7	Other (specify):*											7
8	TOTAL General Services	677,426	318,248	236,742	1,232,416		1,232,416	(10,572)	1,221,844			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,323,079	185,465	261,296	2,769,840		2,769,840		2,769,840			10
10a	Therapy			194,932	194,932	(217,294)	(22,362)		(22,362)			10a
11	Activities	124,552	18,979		143,531		143,531		143,531			11
12	Social Services	97,110			97,110		97,110		97,110			12
13	CNA Training											13
14	Program Transportation		4,426		4,426		4,426		4,426			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,544,741	208,870	486,228	3,239,839	(217,294)	3,022,545		3,022,545			16
	C. General Administration											
17	Administrative			106,965	106,965		106,965	120,333	227,298			17
18	Directors Fees											18
19	Professional Services			107,223	107,223		107,223		107,223			19
20	Dues, Fees, Subscriptions & Promotions			36,083	36,083		36,083	(5,188)	30,895			20
21	Clerical & General Office Expenses	238,734	15,000	11,732	265,466		265,466	12,684	278,150			21
22	Employee Benefits & Payroll Taxes			573,510	573,510		573,510	12,541	586,051			22
23	Inservice Training & Education			8,287	8,287		8,287		8,287			23
24	Travel and Seminar			598	598		598		598			24
25	Other Admin. Staff Transportation			3,073	3,073		3,073		3,073			25
26	Insurance-Prop.Liab.Malpractice			65,554	65,554		65,554		65,554			26
27	Other (specify):* PENALTIES			55,600	55,600		55,600		55,600			27
28	TOTAL General Administration	238,734	15,000	968,625	1,222,359		1,222,359	140,370	1,362,729			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,460,901	542,118	1,691,595	5,694,614	(217,294)	5,477,320	129,798	5,607,118			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38,920	38,920		38,920	100,348	139,268			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			40,047	40,047		40,047		40,047			33
34	Rent-Facility & Grounds			114,000	114,000		114,000	(114,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			192,967	192,967		192,967	(13,652)	179,315			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					217,294	217,294		217,294			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			477,837	477,837		477,837		477,837			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			477,837	477,837	217,294	695,131		695,131			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,460,901	542,118	2,362,399	6,365,418		6,365,418	116,146	6,481,564			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,772)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,800)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,188)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,760)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (15,760)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39	MEDICARE THERAPY	X		217,294	10A	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 217,294		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$		1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS INC	100	BUILDING OWNERS	PROPHETSTOWN			
AMERICAN HEALTH ENTERPRISES	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 114,000	WINNING WHEELS - 100% BUILDING OWNER		\$	(114,000)	1
2	V	30	DEPRECIATION		WINNING WHEELS - 100% BUILDING OWNER		100,348	100,348	2
3	V	17	PROFESSIONAL SERVICES		AMERICAN HEALTH ENTERPRISES INC		29,397	29,397	3
4	V	17	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		90,936	90,936	4
5	V	21	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		12,684	12,684	5
6	V	22	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		12,541	12,541	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 114,000			\$ 245,906	\$ * 131,906	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Lyndon Progress Center (LPC)
For The 12 Periods Ended 12/31/25
90 ADMINISTRATION

EXPENSES		Wheels	STRIVE
5460-90	ADMINISTRATION	244,366	116,185
6460-90	ADMINISTRATIVE	16,648	25,043
5620-90	FICA	17,507	7,793
5640-90	WORKMAN'S COMP	2,172	1,680
5650-90	UNEMPLOYMENT	251	967
5660-90	LIFE INSURANCE	386	112
5665-90	VISION INSURANCE	197	88
5671-90	HEALTH INSURANCE	12,227	19
5675-90	SUPPLEMENTAL INS	-	1,173
5685-90	DENTAL INSURANCE	1,042	-
5690-90	ST & LT DISABILITY INS	1,793	464
5695-90	VOL LIFE INS	-	100
5730-90	CHILD CARE	-	172
5750-90	OTHER	832	-
Total EXPENSES:		297,421	370
		132,392	80
		28,536	
		% of Total Salaries and Benefits	Portion of LPC Salaries and Benefits
Winning Wheels			
Salaries	4,402,487		116,185
Benefits	734,704		16,206
Total Salaries and Benefits	5,137,191	0	132,391
STRIVE			
Salaries	936,963		25,043
Benefits	170,313		3,493
Total Salaries and Benefits	1,107,276	0	28,536
Day Treatment			
Salaries	195,532		5,220
Benefits	35,257		728
Total Salaries and Benefits	230,789	0	5,948
Frontier Hollow			
Salaries	179,135		4,638
Benefits	25,934		647
Total Salaries and Benefits	205,069	0	5,285
Day Care			
Salaries	252,631		6,876
Benefits	51,414		959
Total Salaries and Benefits	304,045	0	7,836
Pinnacle Place			
Salaries	458,743		12,116
Benefits	76,988		1,690
Total Salaries and Benefits	535,731	0	13,806
Big Meadows			
Salaries	3,447,246		90,936
Benefits	573,511		12,684
Total Salaries and Benefits	4,020,757	0	103,619
Total			
Salaries	9,872,737		261,014
Benefits	1,668,121		36,407
Total Salaries and Benefits	11,540,858	1	297,421

Ownership Listing-2

ID# 0021394

Ending: 12/31/2024

-Names of trust beneficiaries must be listed.

Co. /Home Office

Ownership

	First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage
76								76
77								77
78								78
79								79
80								80
81								81
82								82
83								83
84								84
85								85
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148								148
149								149
150								150

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ADMINISTRATOR	ADMINISTRATOR				40	100.00	SAL/BEN	\$ 82,238	17	1
2	CORPORATE	CFO,CEO, ASST				30	0.50	SAL/BEN	48,050	17	2
3	ALAN GAPINSKI			100.00		2	4.00		0		3
4	MANAGEMENT FEES FROM WINNING WHEELS										4
5	AMERICAN HEALTH ENTERPRISES										5
6	MANAGEMENT FEES FROM WINNING WHEELS				64,500						6
7	MANAGEMENT FEES FROM STRIVE				15,750						7
8	MANAGEMENT FEES FROM PINNACLE PLACE				25,800						8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 130,288		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization AMERICAN HEALTH ENTERPRISES
Street Address 501 6TH AVE W
City / State / Zip Code LYNDON IL 61261
Phone Number (815-778-3683
Fax Number (815-778-4503

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMIN HOME OFFICE SAL	GROSS REVENUE	16,101,552	4	\$ 55,070	\$		\$ 0	1
2	17	ADMIN SALARY	DIRECT COST	1	1	29,397		1	29,397	2
3	22	EMPLOYEE BENEFITS	% OF PAYROLL	71,517	4	73,017			0	3
4	21	OFFICE COSTS	GROSS REVENUE	16,101,552	4	10,126			0	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 167,610	\$		\$ 29,397	25

American Health Enterprises, Inc. (AHE)
For The 12 Periods Ended 12/31/2025
Expense Statement

	2025 Total from G/L	Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	Home Office Allocation	AHE Corp	Total	
Expenses									
SALARIES									
5340 ADMINISTRATORS	\$ 214,389	\$ 35,076	\$ 29,397	\$ 128,373	\$ 24,872			\$ 217,718	\$ 3,329
5360 FINANCE	\$ 53,918					\$ 55,070	\$ -	\$ 55,070	\$ 1,152
5460 CORPORATE	\$ 2,893	\$ -	\$ -	\$ 3,000	\$ -	\$ -	\$ -	\$ 3,000	\$ 107
Total SALARIES:	\$ 271,200	\$ 35,076	\$ 29,397	\$ 131,373	\$ 24,872	\$ 55,070	\$ -	\$ 275,788	\$ 4,588
BENEFITS									
5620 FICA	\$ 20,747					\$ 20,747		\$ 20,747	\$ -
5640 WORKMENS COMP	\$ 226					\$ 226		\$ 226	\$ -
5650 UNEMPLOYMENT	\$ 7,852					\$ 7,852		\$ 7,852	\$ -
5660 INSURANCE	\$ 25,137					\$ 25,137		\$ 25,137	\$ -
5690 401K	\$ 17,555					\$ 17,555		\$ 17,555	\$ -
5750 OTHER	\$ -					\$ -		\$ -	\$ -
Total BENEFITS:	\$ 71,517	\$ -	\$ -	\$ -	\$ -	\$ 71,517	\$ -	\$ 71,517	\$ -
CONTRACT SERVICES									
6460 ADMINISTRATION	\$ -					\$ -		\$ -	\$ -
6470 DATA PROCESSING	\$ 7,800					\$ -	\$ 7,800	\$ 7,800	\$ -
Total CONTRACT SERVICES:	\$ 7,800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 7,800	\$ 7,800	\$ -
SUPPLIES									
7420 MAINTENANCE	\$ -					\$ -	\$ -	\$ -	\$ -
7440 TRANSPORTATION	\$ -					\$ -	\$ -	\$ -	\$ -
7460 OFFICE	\$ -					\$ -	\$ -	\$ -	\$ -
7470 COMPUTER SUPPLIES	\$ -					\$ -	\$ -	\$ -	\$ -
Total SUPPLIES:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
GENERAL & ADMIN.									
8080 CABLE TV	\$ -					\$ -		\$ -	\$ -
9010 TELEPHONE	\$ 1,500					\$ 1,500		\$ 1,500	\$ -
9020 DUES & SUBSCRIPTIONS	\$ 133					\$ 133	\$ -	\$ 133	\$ -
9040 INSURANCE	\$ -					\$ -		\$ -	\$ -
9080 POSTAGE	\$ 73					\$ 73		\$ 73	\$ -
9100 LEGAL & ACCOUNTING	\$ -					\$ -	\$ -	\$ -	\$ -
9120 RECRUITMENT	\$ -					\$ -		\$ -	\$ -
9140 TRAVEL & SEMINAR	\$ 264					\$ 264		\$ 264	\$ -
9160 LICENSE & TAXES	\$ 75					\$ 75		\$ 75	\$ -
TRAINING	\$ 310					\$ 310		\$ 310	\$ -
9180 OTHER	\$ 9,271					\$ 9,271	\$ -	\$ 9,271	\$ -
9190 COMMUNITY RELATIONS	\$ -					\$ -		\$ -	\$ -
Total GENERAL & ADMIN.:	\$ 11,626	\$ -	\$ -	\$ -	\$ -	\$ 11,626	\$ -	\$ 11,626	\$ -
INTEREST									
9340 INTEREST - AUTOS	\$ -							\$ -	\$ -
Total INTEREST:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Expenses:	\$ 362,143	\$ 35,076	\$ 29,397	\$ 131,373	\$ 24,872	\$ 138,213	\$ 7,800	\$ 366,731	

FORMULA
ADMIN SAL * TOTAL ON INC STATE / TOTAL OF ADMIN SALARIES

Reimbursed by the facilities

Reimbursed by the facilities

Allocation to the Cost Reports		Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	
Revenues	\$ 16,101,552	\$ 8,176,227	\$ 5,254,719	\$ 1,562,851	\$ 1,107,755	
		50.78%	32.63%	9.71%	6.88%	
Total Salary for benefit %	\$ 275,788	\$ 63,040	\$ 47,369	\$ 136,718	\$ 28,661	
		22.86%	17.18%	49.57%	10.39%	
Employee Benefits	\$ 275,788	\$ 16,689	\$ 12,541	\$ 36,197	\$ 7,588	\$ 73,017
Home Office Costs	\$ 10,127	\$ 5,142	\$ 3,305	\$ 983	\$ 697	\$ 10,126
Administrator	\$ 220,718	\$ 35,076	\$ 29,397	\$ 131,373	\$ 24,872	
Home Office Salaries	\$ 55,070	\$ 27,964	\$ 17,972	\$ 5,345	\$ 3,789	\$ 55,070
	\$ 561,703	\$ 84,871	\$ 63,215	\$ 173,898	\$ 36,946	\$ 138,213

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	36,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	38,697	2
3. Under or (over) accrual (line 2 minus line 1).				\$	2,697	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	37,350	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	40,047	7
Assessed Value from Real Estate Tax Bill:	2024	363,872	8			
Real Estate Tax Bill for Calendar Year:	2020	37,852	9			
	2021	38,383	10			
	2022	40,821	11			
	2023	38,324	12			
	2024	38,697	13			
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	BIG MEADOWS	COUNTY	CARROLL
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CONTACT PERSON REGARDING THIS REPORT Robin Landis

A. Summary of Real Estate Tax Cost

[illegible]

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

CARROLL COUNTY
LYDIA HUTCHCRAFT
P.O. BOX 198
MOUNT CARROLL, IL 61053-0198
www.carrollcountyil.gov

CARROLL COUNTY PROPERTY TAX BILL
2024 TAXES PAYABLE 2025

PLEASE READ the instructions on the back of this bill regarding when to pay and where to pay your taxes. Additional information is provided for changing your mailing address and tax exemptions in which you might be entitled.

The County Collector only collects your taxes and is not responsible for the amount of your assessment or the amount of your tax bill. We will be happy to assist you or direct you to the proper authority regarding questions about your tax bill.

LEGAL DESC:
77 SAV L73 S3 T24 R3 PT.660' X 880' SE.& .28 AC ADJ N
SIDE B77 P347 08-000-073-0 0

PROPERTY INDEX NUMBER (PIN) 08-07-03-400-003	
PROPERTY CLASS	0050
FIRST DUE DATE	07/03/2025
FIRST INSTALLMENT	\$19,348.28
SECOND DUE DATE	09/03/2025
SECOND INSTALLMENT	\$19,348.28
PRIOR TAX SOLD	
FORFEITED	\$0.00
1977 EQUALIZED 0	
SAF BASE 0	
FAIR CASH VALUE 1,091,730	
TOTAL ACRES 13.33	
YIF BASE 0	
LAND VALUE 49,588	
+ BUILDING VALUE 314,284	
+ FARM BUILDING 0	
+ FARM LAND 0	
+ HOME IMPROVEMENT 0	
+ DISABLED VET EXEMPT 0	
ASSESSED VALUE 363,872	
x STATE MULTIPLIER 1.0000	
= EQUALIZED VALUE 363,872	
+ OWNER OCCUPIED 0	
+ SENIOR EXEMPT 0	
+ FREEZE EXEMPTIONS 0	
+ RT VETERAN EXEMPT 0	
+ DISABLE VET EXEMPT 0	
+ DISABLE PER EXEMPT 0	
= NET TAXABLE VAL 363,872	
x TAX RATE 10.63466	
= CURRENT TAX \$38,696.56	
+ ENTERPRISE ZONE \$0.00	
+ FORFEITURE BAL \$0.00	
= TOTAL TAX DUE \$38,696.56	

NAME: WINNING WHEELS INC
%GAPINSKI AL
701 E THIRD ST
PROPHETSTOWN IL 61277-0000

TAX CODE 08003 CARROLL COUNTY ITEMIZED STATEMENT TOWNSHIP Savanna Township

Taxing Body	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	% of Total
TRI-TWP-MUNICIPAL-AIRPRT	0.06985	\$221.01	0.06843	\$249.00	0.64
CARROLL COUNTY	0.61100	\$1,933.27	0.57877	\$2,106.00	5.44
CARROLL COUNTY	0.13129	\$415.42	0.11949	\$434.79	1.12
HIGHLAND JC 519	0.53845	\$1,703.71	0.52089	\$1,895.37	4.90
HIGHLAND JC 519	0.00668	\$21.14	0.00770	\$28.02	0.07
SAVANNA LIBRARY DIST	0.16346	\$517.21	0.15539	\$565.43	1.46
SAVANNA LIBRARY DIST	0.04167	\$131.84	0.03790	\$137.90	0.36
SAVANNA PARK DIST	0.41808	\$1,322.85	0.38522	\$1,401.71	3.62
SAVANNA PARK DIST	0.08057	\$254.93	0.07285	\$265.08	0.69
SAVANNA TWP	0.24689	\$781.18	0.23441	\$852.95	2.20
SAVANNA R&B	0.19902	\$629.72	0.18896	\$687.57	1.78
WEST CARROLL U314	5.29022	\$16,738.79	4.90166	\$17,835.77	46.09
WEST CARROLL U314	0.37707	\$1,193.08	0.35572	\$1,294.36	3.34
SAVANNA CORP	1.55973	\$4,935.15	1.56213	\$5,684.15	14.69
SAVANNA CORP	1.58863	\$5,026.58	1.44514	\$5,258.46	13.59
TOTALS	11.32261	\$35,825.00	10.63466	\$38,696.56	

LOCATION: 1000 LONGMOOR
SAVANNA, IL
Owner Name: WINNING WHEELS INC
MAKE CHECKS PAYABLE TO CARROLL COUNTY TREASURER

RETURN THIS PORTION WITH PAYMENT

FOR THE YEAR	2024		FORFEITED TAXES OR YEAR	\$0.00
PROPERTY INDEX NUMBER (PIN)	08-07-03-400-003		FIRST INSTALLMENT	\$19,348.28
			DUE DATE	07/03/2025
PAID BY	PENALTY	COSTS		
TOTAL TAX DUE	\$38,696.56		AMOUNT PAID	



NAME: WINNING WHEELS INC
ADDRESS: %GAPINSKI AL
701 E THIRD ST
PROPHETSTOWN, IL 61277-0000

RETURN THIS PORTION WITH PAYMENT

FOR THE YEAR	2024		FORFEITED TAXES OR YEAR	\$0.00
PROPERTY INDEX NUMBER (PIN)	08-07-03-400-003		SECOND INSTALLMENT	\$19,348.28
			DUE DATE	09/03/2025
PAID BY	PENALTY	COSTS		
TOTAL TAX DUE	\$38,696.56		AMOUNT PAID	



NAME: WINNING WHEELS INC
ADDRESS: %GAPINSKI AL
701 E THIRD ST
PROPHETSTOWN, IL 61277-0000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,835 B. General Construction Type: Exterior BRICK Frame CEMENT BLOCK Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. List the bed capacity for the building if it differs from the licensed total. NA
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? YES
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY GROUND	580,800	2001	\$ 13,900	1
2					2
3	TOTALS	580,800		\$ 13,900	3

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LIFT STATION PUMP WORK	2020	\$ 3,264	\$ 326	10	\$ 326	\$	\$ 2,066	37
38	LIFT STATION PUMP WORK	2020	2,613	373	7	373		2,301	38
39	ELECTRICAL REPAIR LIFT STATION	2020	985	141	7	141		857	39
40	A/C REPAIRS	2020	2,900	414	7	414		2,519	40
41	REWORK EXTRA LIFT STATION PUMP	2020	6,147	410	15	410		2,494	41
42	DINING ROOM ROOF REPLACEMENT	2020	16,816	3,027	10	3,027		16,816	42
43	DINING ROOM ROOF A/C MOVE	2020	5,150	613	7	613		3,801	43
44	DINING ROOM ROOF A/C MOVE	2020	4,886	326	5	326		4,886	44
45	BOILER PUMP	2021	4,019	574	10	574		2,777	45
46	UNIT DOOR	2021	4,102	586	10	586		2,754	46
47	STEEL DOOR	2021	3,294	471	7	471		2,184	47
48	BACK SIDEWALK	2022	13,655	1,366	10	1,366		4,781	48
49	ROOF UNIT	2022	19,318	966	20	966		3,139	49
50	MAINTENANCE BUILDING NEW ROOF	2024	3,200	89	3	89		178	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,891,524	\$ 100,348		\$ 100,348	\$	\$ 2,553,640	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$162,857	\$33,363	\$33,363	\$	7	\$83,081	71
72	Current Year Purchases	9,451	1,500	1,500	0	7	1,500	72
73	Fully Depreciated Assets	903,100					903,100	73
74								74
75	TOTALS	\$1,075,408	\$34,863	\$34,863	\$0		\$987,681	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINTENANCE	2004 FORD F-250	2020	\$20,090	\$2,870	\$2,870	\$	7	\$16,503	76
77	MAINTENANCE	WESTERN SNOW PLOT	2020	8,308	1,187	1,187		7	7,927	77
78										78
79										79
80	TOTALS			\$28,398	\$4,057	\$4,057	\$		\$24,430	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,009,230	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$139,268	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$139,268	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,565,751	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:WINNING WHEELS INC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1968	83	09/19/2001	\$114,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		83		\$114,000			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:☒ YES☐ NOTerms:VARIOUS*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

10. Effective dates of current rental agreement:

Beginning09/19/2001

Ending12/31/2025

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10.A.3	hrs	\$	6,044	\$ 89,343	\$	6,044	\$ 89,343	1
2	Licensed Speech and Language Development Therapist	10.A.3	hrs		5,074	82,280		5,074	82,280	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.A.3	hrs		994	15,126		994	15,126	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	3								13
14	TOTAL			\$	12,112	\$ 186,749	\$	12,112	\$ 186,749	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$5,306	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance COST)	521,657		3
4	Supply Inventory (priced at COST)	20,593		4
5	Short-Term Investments			5
6	Prepaid Insurance	6,277		6
7	Other Prepaid Expenses	7,922		7
8	Accounts Receivable (owners or related parties)	109,070		8
9	Other(specify): HFS INCENTIVES	87,563		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$758,388	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,150		12
13	Land	131,520		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,103,806		16
17	Accumulated Depreciation (book methods)	(1,019,768)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$232,708	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$991,096	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$541,218	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,037		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,434		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,388		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$861,077	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	57,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$57,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$918,077	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$73,019	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$991,096	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 883,998	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 883,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(810,979)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (810,979)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,019	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BIG MEADOWS

0021394

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,380,345	1
2	Discounts and Allowances for all Levels	(24,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,356,345	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	217,294	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 217,294	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,772	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,772	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION / VENDING	773	28
28a	HFS INCENTIVE FUNDS	190,541	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 191,314	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,771,733	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,232,416	31
32	Health Care	3,239,839	32
33	General Administration	1,222,359	33
	B. Capital Expense		
34	Ownership	192,967	34
	C. Ancillary Expense		
35	Special Cost Centers	217,294	35
36	Provider Participation Fee	477,837	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,582,712	40
41	Income before Income Taxes (line 30 minus line 40)**	(810,979)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (810,979)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,177,943.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,880,962.00	45
46	MMAI-Medicaid is the Primary Payer	91,676.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,224,813.00	48
49	Medicare Part A		49
50	Other-(specify) SUPPLIES	4,951.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,380,345	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,913	2,094	\$ 122,531	\$ 58.52	1
2	Assistant Director of Nursing	2,405	2,733	121,266	44.37	2
3	Registered Nurses	8,112	9,553	403,819	42.27	3
4	Licensed Practical Nurses	8,285	9,943	400,173	40.25	4
5	CNAs & Orderlies	49,729	62,773	1,275,290	20.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,677	4,279	90,631	21.18	9
10	Activity Assistants	1,808	2,021	33,921	16.78	10
11	Social Service Workers	1,957	2,093	50,953	24.34	11
12	Dietician					12
13	Food Service Supervisor	2,039	2,323	50,426	21.71	13
14	Head Cook	5,847	6,570	110,154	16.77	14
15	Cook Helpers/Assistants	8,722	9,535	151,906	15.93	15
16	Dishwashers					16
17	Maintenance Workers	6,379	6,872	135,701	19.75	17
18	Housekeepers	7,338	8,065	128,312	15.91	18
19	Laundry	5,114	5,823	100,927	17.33	19
20	Administrator	1,326	1,472	75,146	51.05	20
21	Assistant Administrator					21
22	Other Administrative	1,870	2,163	81,100	37.49	22
23	Office Manager	1,888	2,068	39,514	19.11	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,706	2,027	42,974	21.20	31
32	Other Health Care UNIT DIRECTOR	1,817	2,103	46,157	21.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,932	144,510	\$ 3,460,901 *	\$ 23.95	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	150	\$ 10,950	1.3	35
36	Medical Director	130	30,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	90	4,470	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	370	\$ 45,420		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,140	\$ 91,200	10.3	50
51	Licensed Practical Nurses	380	22,894	10.3	51
52	Certified Nurse Assistants/Aides	3,390	142,345	10.3	52
53	TOTAL (lines 50 - 52)	4,910	\$ 256,439		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
JULIE JOHNSON	ADMIN	0	\$ 29,397	Workers' Compensation Insurance	\$	63,115	IDPH License Fee	\$
LISTED UNDER AMERICAN HEALTH ENTERPRISES			(29,397)	Unemployment Compensation Insurance			Advertising: Employee Recruitment	20,640
THROUGH MARCH 31, 2026 ONLY				FICA Taxes		260,945	Health Care Worker Background Check	
				Employee Health Insurance		193,275	(Indicate # of checks performed 45)	1,321
				Employee Meals			Patient Background Checks	60
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	7,570
				LIFE INSURANCE		4,323	DUES / SUBSCRIPTIONS	936
				DENTAL INSURANCE		19,566	ADVERTISING/MARKETING	5,013
				VISION INSURANCE		3,937	LICENSE	543
				TUITION ASSISTANCE		1,024		
				EMPLOYEE RECOGNITION		10,979	Less: Public Relations Expense	()
				PHYSICALS/DRUG TESTS		1,801	PAC and Lobbying payments	(2,382)
				DIABILITY INSURANCE		14,545	All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,	\$	573,510	TOTAL (agree to Sch. V,	\$ 33,701
(List each licensed administrator separately.)			\$	line 22, col.8)			line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
AMERICAN HEALTH ENTERPRISES CONTRACT			\$ 39,750			\$	Out-of-State Travel	\$
PLYMOUTH MANAGEMENT SERVICES			67,215					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 106,965				In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
JOHN PYSE CONSULT	IT CONSULT		\$ 17,469					
MIDWEST AUTO TIME	TIMECLOCK MAINT		1,020					
POINTCLICKCARE	EHR SOFTWARE		56,374					
BAMBOO	PAYROLL/HR SYSTEM		3,570					
ABILITY/ESOLUTIONS	BILLING SOFTWARE		9,760					
ONSHIFT	SCHEDULE SOFTWARE		6,840					
SOHPOS	COMPUTER DEFENSE		1,402					
MIDWEST GROUP BENEFITS	COBRA		918					
SAGE	ACCOUNTING SOFTWARE		3,025				Seminar Expense	
BARRACUDA BACK UP	FIRM SOFTWARE		4,355				HOTEL	598
POLSINELLI	LEGAL		420					
DEB CONNERY CONSULTING	SOCIAL WORK CONSULT		2,070					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 107,223				(agree to Sch. V,	
							line 24, col. 8)	\$ 598

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	5,188
	5,188 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	2,382
	2,382 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	7,570
	7,570 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 36,062 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 477,837

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

YES If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ NONE

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$ 6,772
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

YES

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ NO
- (13)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

YES

See page 39 of the instructions for details.

Attach invoices and a summary of services for all architect and appraisal fees.

BIG MEADOWS - 0021394
Report Period Beginning 01/01/2025
Report Period Ending 12/31/2025

Total Cost

1 Name & Title	Julie Johnson	
Date Traveled	9/11/25-9/13/25	
Location	Peoria IL	
Sponsor	IHCA	
Total Cost	\$597.98 Hotel/ \$0 Travel / \$0 Conference / \$0 Meals / \$597.98 Total	\$597.98
Total Seminar		\$0.00
Mileage/Hotels		\$597.98
		\$597.98
Total - Schedule V, Line 24 - Other		\$597.98
Total - Schedule V, Line 24 - Adjustments		\$0.00
Total - Schedule V, Line 24 - 8		\$597.98

BIG MEADOWS - 0021394
Report Period Beginning 01/01/2025
Report Period Ending 12/31/2025

Total Cost

1	Name & Title	All Staff and All Positions to replace in person inservices	
	Date Of Training	Continuously required throughout the year	
	Location	Online	
	Title	Relias Training	
	Sponsor	Relias Healthcare Training and Performance Solutions	
	Total Cost	\$8,461.00	8,461.00

2

Total Training	\$8,461.00
	\$8,461.00

Total - Schedule V, Line 23 - Inservice Training and Education	\$8,461.00
Total - Schedule V, Line 23 - 8	\$8,461.00